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| Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé<br>**POLICY** | **REGIONAL**<br>Applicable to all WRHA governed facilities and Sites (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement. | | Level<br>**1** |
| | Policy Name:<br>**Patient Safety Events: Management and Disclosure of Occurrences, Near Misses and Critical Incidents** | Policy Number:<br>10.50.020 | Page:<br>1 of 9 |
| | Approval Signature:<br>*Original Signed by R. Cloutier* | Section:<br>**QUALITY & RISK MANAGEMENT** | |
| | Date:<br>**December 2019** | Supercedes:<br>**April 2014** | |

## 1.0 PURPOSE:

1.1 To establish procedures for disclosing, reporting, documenting, and investigating Patient Safety Events.

1.2 To ensure a compassionate, transparent, timely and respectful approach for managing Patient Safety Events inclusive of Patients, and when appropriate their Family.

1.3 To support a culture of safety through reporting and learning from Patient Safety Events.

1.4 To enhance the safety of Patients by promoting learning from Patient Safety Events.

1.5 To fulfill the requirements for Patient Safety Events as outlined in the *Regional Health Authorities Act*.

## 2.0 DEFINITIONS:

2.1 Apology: A genuine expression that one is sorry for what has happened. An apology is stated empathically and sincerely, and contains the word 'I am/we are sorry'. An apology is not necessarily an acceptance of responsibility for what has happened, but can acknowledge responsibility when indicated through incident analysis.

2.2 Critical Incident (CI): As set out in the *Regional Health Authorities Act*, means:

An unintended event that occurs when health services are provided to a Patient and result in a consequence to him or her that:

- is serious and undesired, such as death, disability, injury, or harm, unplanned admission to hospital or unusual extension of a hospital stay, and;
- does not result from the Patient's underlying health condition or from a risk inherent in providing the health services.

2.3 Critical Incident Review Committee: a committee of one or more individuals formed for the purpose of reviewing a Critical Incident.

2.4 Disclosure: An ongoing process that includes sharing information with the Patient or Persons Permitted to Exercise the Rights of an Individual as defined in the WRHA Policy 10.40.040 Access to Personal Health Information Policy about the care provided, as well as responding to questions.

2.5 Family: Is defined by the Patient and includes all those persons that the Patient considers Family. This may include, but is not limited to: life-partners, parents, children, grandparents, other relatives, friends, neighbours and community members.

2.6 Health Care Provider: Includes, but is not limited to, physicians, nurse practitioners, physician/clinical assistants, nurses, and allied health professionals.

2.7 Near Miss/Good Catch: Is an event or situation that could have resulted in an accident, injury or illness to a Patient, but did not, either by chance or through timely intervention (i.e. prevention or mitigation).

2.8 Occurrence: An event or situation that resulted in an unintended and undesired outcome to a Patient that did not meet the definition of a Critical Incident.
An unintended event or situation that resulted, or could have resulted, in an undesired outcome to a Patient that did not meet the definition of a Critical Incident.

2.9 Patient: Patient, client, individual or resident receiving healthcare from a WRHA facility, program or funded site.

2.10 Patient Safety Event: A general term referring to a Near Miss/Good Catch, Occurrence, and Critical Incident, where an event or situation, resulted, or could have resulted, in unintended harm to the Patient, and/or damage to, or loss of, equipment or property.

2.11 Programs: Includes any health care services provided by the WRHA.

2.12 RL Solutions Healthcare Risk Management Software (RL): A software application

system used for reporting, tracking and managing Patient Safety Events.

2.13 Safety Huddle: A brief post event discussion to identify any safety concern that led to the Patient Safety Event and supports the Patient, Family and staff's emotional and physical needs.

2.14 Site: Includes funded healthcare facilities in all sectors, community areas, and Programs, within the WRHA.

2.15 Staff: All persons employed within the WRHA, including members of the medical Staff, physicians, volunteers, board members, students, and other individuals associated through legal contracts.

## 3.0 POLICY:

3.1 Staff observing or involved in a Patient Safety Event shall follow the procedures for responding to and reporting events as outlined in this policy.

3.2 With the goal of encouraging a culture of reporting and applied learning, the WRHA shall facilitate Staff, Patients, Family and the general public to report Patient Safety Events.

3.3 Sites/Programs shall operationalize WRHA procedures to comply with the reporting and management of Patient Safety Events.

3.4 Follow-up actions and recommendations arising from a Patient Safety Event shall be monitored and analyzed for the purpose of applied learning and system improvements.

## 4.0 PROCEDURE:

### 4.1 RESPONDING TO AND REPORTING PATIENT SAFETY EVENTS

4.1.1 Staff shall ensure Patients are safeguarded and receive immediate clinical care as needed.

4.1.2 Staff, Patients, or members of the public shall report the Patient Safety Event through RL or the WRHA telephone line (204-788-8222). Reporting can be done anonymously. Information about the WRHA telephone line, including the telephone number, can be found on the publicly accessible WRHA website https://www.wrha.mb.ca/quality/patientsafety/index.php

4.1.3 Staff shall notify their immediate supervisor or Site/Program delegate and to the most responsible Health Care Provider of the Patient Safety Event. In the case of a Near Miss/Good Catch, notification is discretionary.

4.1.4 The immediate supervisor or Site/Program delegate shall ensure:

a) The location of the event, including pertinent equipment and supplies, are secured if necessary.

b) A Safety Huddle is coordinated with Staff, depending on the level of harm.

c) The Patient Safety Event is verbally Disclosed as soon as possible to the Patient and/or Family, when there has been any harm, or if there is a risk of potential future harm. In the case of a Near Miss/Good Catch, Disclosure is discretionary based on whether it is felt the Patient and/or Family would benefit from knowing.

d) With Disclosure, an Apology is provided and practical, emotional, and psychological support is offered to the Patient and/or Family.

e) The Patient Safety Event and communication to the Patient and/or Family are documented in Patient's health record.

f) Staff support is available as required.

g) The Patient Safety Event is reported in RL or if RL is unavailable, by WRHA telephone line (204-788-8222).

h) The Patient Safety Event is evaluated against the criteria for the:
- Mandatory reporting of Abuse and Neglect of Adults and Children in Need of Protection policy: http://home.wrha.mb.ca/corp/policy/files/80.00.010.pdf
- for the Disclosure of Personal Health Information Without Consent policy: http://home.wrha.mb.ca/corp/policy/files/10.40.141.pdf
- Mandatory reporting of Adverse Drug Reactions Policy: *link to be added once policy is finalized)*
- Mandatory reporting of Medical Device Incidents Policy: *link to be added once policy is finalized)*

4.1.5 Sites/Programs shall reference the Standard Operating Procedure (SOP) for Initial Event Management: http://home.wrha.mb.ca/quality/files/InitialManagement.pdf

4.1.6 WRHA Quality Improvement and Patient Safety shall review Patient Safety Events flagged in RL as requiring potential verification as a Critical Incident (CI).

## 4.2 REVIEW OF OCCURRENCE OR NEAR MISS EVENTS

4.2.1 Site/Program delegate shall review the Occurrence or Near Miss/Good Catch event according to the Standard Operating Procedure (SOP) Management of Occurrence and Near Miss Events: http://home.wrha.mb.ca/quality/event-learning.php

4.2.2 Site leadership and/or regional Programs shall monitor and analyze trends and themes within their respective Program.

4.2.3 WRHA Quality Improvement and Patient Safety shall:

a) Maintain a regional database for all Patient Safety Events for tracking and identifying trends or themes.

b) Monitor and analyze trends and themes for the WRHA and generate regional reports.

c) Review Occurrences and Near Misses/Good Catches when required.

4.2.4 Site/Program delegate shall review the Occurrence or Near Miss/Good Catch event according to the Standard Operating Procedure (SOP) Management of Occurrence and Near Miss Events: http://home.wrha.mb.ca/quality/event-learning.php

4.2.5 Site leadership and/or regional Programs shall monitor and analyze trends and themes within their respective Program.

4.2.6 WRHA Quality Improvement and Patient Safety shall:

a) Maintain a regional database for all Patient Safety Events for tracking and identifying trends or themes.

b) Monitor and analyze trends and themes for the WRHA and generate regional reports.

c) Review Occurrences and Near Misses/Good Catches when required.

## 4.3 REVIEW OF CRITICAL INCIDENT EVENTS

4.3.1 A Patient Safety Consultant (or delegate) shall review the CI event according to the Standard Operating Procedure (SOP) Management of Critical Incident Events: http://home.wrha.mb.ca/quality/files/CIReviewProcess.pdf

4.3.2 Site leadership (or delegate) shall be responsible to:

a) Provide Disclosure, along with an Apology, to the Patient, and when appropriate, to the Family, as soon as possible. The initial Disclosure process shall include:

- The definition of a CI.
- The facts of what actually occurred with respect to the CI.
- The consequences for the Patient as they become known.
- The actions taken and to be taken to address the consequences of the CI, including any health services, care or treatment that are advisable.
- An expression of regret that the event occurred.
- That a review will take place and the CI will be registered with Manitoba Health Seniors and Active Living (MHSAL).
- The provision of a copy of the Manitoba Institute for Patient Safety (MIPS) brochure as appropriate: https://mips.ca/assets/guide_to_ci_and_disclosure-update-2016.pdf.
- That the Patient and Family will be contacted by the CIRC and offered an opportunity to share their experience and provide suggestions for improvement.
- Notification that a verbal summary of the findings and recommendations will be shared with the Patient and Family at the end of the review.
- Notification that the CI review and report are confidential and will only be shared with MHSAL and leadership.
- Explanation that the goal is to improve patient safety and mitigate the risk of a similar event and harm from occurring again.

b) Ensure that the Critical Incident (CI) Disclosure Record is completed: http://home.wrha.mb.ca/hinfo/rhif/files/CI_smpl.pdf

- The CI Disclosure record may be shown and a copy provided at no cost to the Patient and Family.
- A copy shall be sent to WRHA Quality Improvement and Patient Safety.

c) Ensure the Patient and/or Family have been offered dedicated support and opportunities to receive updates about the progress of the review throughout the CI review process.

d) Ensure the Patient and/or Family are provided with final verbal Disclosure of the findings and recommendations.

e) Ensure the CIRC has access to information, equipment, reports, and Staff.

f) Notify site insurance provider when appropriate.

g) Implement follow-up actions and recommendations arising from CI Reviews

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4.3.3 WRHA Quality Improvement and Patient Safety shall be responsible to:

a) Ensure a review is completed by the appointment of a Critical Incident Review Committee.

b) Ensure a written final report is completed within 88 business days of designation, and is provided to the senior leader(s) of the Site/Program, as well as to MHSAL.

c) Ensure compliance with MHSAL Critical Incident reporting and investigation legislation: https://www.gov.mb.ca/health/patientsafety/ci/index.html

d) Monitor and analyze trends, themes, follow-up actions and recommendations for the WRHA.

e) Maintain a regional database for all Patient Safety Events for tracking trends or themes and generating regional reports.

## 5.0 **REFERENCES:**

5.1 Accreditation Canada (2019). *Required Organizational Practices: Patient Safety Incident Disclosure.* http://www.wrha.mb.ca/quality/files/2019ROPHandbook.pdf

5.2 Accreditation Canada (2019). *Required Organizational Practices: Patient Safety Incident Management.* http://www.wrha.mb.ca/quality/files/2019ROPHandbook.pdf

5.3 Canadian Patient Safety Institute. (2011). *Canadian disclosure guidelines: Being open with patients and families.* https://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Documents/CPSI%20Canadian%20Disclosure%20Guidelines.pdf

5.4 Canadian Patient Safety Institute (2012). *Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework.*

http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF

5.5 Government of Manitoba (2006, May 3) *The Regional Health Authorities Amendment Act.* http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php

5.6 Government of Manitoba (2007).*The Apology Act.* web2.gov.mb.ca/laws/statutes/ccsm/a098e.php

5.7 Government of Manitoba (2019). *The Personal Health Information Act.* web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

5.8 Government of Manitoba. (2015). *An Inquest into the Death of: HEATHER DAWN BRENAN. http://www.manitobacourts.mb.ca/site/assets/files/1051/heather_brenan_inquest_report_-_december_22_2015_wiebe.pdf*

5. 9 Government of Manitoba. (2019). *Critical Incident Reporting and Investigation.* https://www.gov.mb.ca/health/patientsafety/ci/index.html

5.10 HIROC (2019). *Disclosure of Incidents.* https://www.hiroc.com/resources/risk-notes/disclosure-incidents

5.11 HIROC (2019). *Critical Incidents – Disclosure Documentation.* https://www.hiroc.com/resources/risk-notes/critical-incidents-disclosure-documentation

5.12 Manitoba Institute for Patient Safety (2018). *A Guide to a Critical Incident and Disclosure: Information for Patients and Families.* https://mips.ca/assets/guide_to_ci_and_disclosure-update-2016.pdf

5.13 Northern Health Region (March 12, 2018). *Disclosure of Patient Safety Incidents (Critical Incidents and Occurrences) Policy AD-06-80.*

5.14 WRHA. (2019). *Disclosure of Personal Health Information Without Consent policy:* http://home.wrha.mb.ca/corp/policy/files/10.40.141.pdf

5.15 WRHA. (2016). *Mandatory reporting of Abuse and Neglect of Adults and Children in need of protection.* http://home.wrha.mb.ca/corp/policy/files/80.00.010.pdf

5.16 WRHA. (2019). *Mandatory reporting of Adverse Drug Reactions Policy: link to be added once policy is finalized)*

5.17 WRHA. (2019). *Mandatory reporting of Medical Device Incidents Policy: link to be added once policy is finalized)*

5.18 WRHA. (2019). *Patient Safety Event Standard Operating Procedures.* http://home.wrha.mb.ca/quality/event-learning.php

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